

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703

E-Mail: [web@drl.state.wi.us](mailto:web@drl.state.wi.us)  
Website: <http://www.drl.state.wi.us>

## APPLICATION INFORMATION FORM

### ATTENTION

### IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 working days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925**. The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: <http://www.drl.state.wi.us>. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days of receipt of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: <http://www.drl.state.wi.us>. Look under "Business/Professional License Lookup" for your official credential number and grant date.

# Department of Regulation & Licensing

State of Wisconsin

(608) 266-2811

TTY# (608) 267-2416 <sup>1</sup>hearing or speech

TRS# 1-800-947-3529 <sup>1</sup>impaired only

P.O. Box 8935, Madison, WI 53708-8935

E-Mail: [web@drl.state.wi.us](mailto:web@drl.state.wi.us)

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FAX #: (608) 261-7083

## PHYSICAL THERAPISTS AFFILIATED CREDENTIALING BOARD

### APPLICATION FOR A LOCUM TENENS LICENSE TO PRACTICE PHYSICAL THERAPY

Information requested is required for processing.

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#### PLEASE TYPE OR PRINT IN INK

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Former Name(s) (If Applicable): \_\_\_\_\_

Street Address: \_\_\_\_\_  
(A Post Office Box is NOT Acceptable)

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnic and gender status information is optional and is for research and reporting to the Equal Employment Opportunity Commission.

RACE: \_\_\_\_\_ (1) White, not of Hispanic Origin \_\_\_\_\_ (4) American Indian or Alaskan  
\_\_\_\_\_ (2) Black, not of Hispanic Origin \_\_\_\_\_ (5) Asian or Pacific Islander  
\_\_\_\_\_ (3) Hispanic \_\_\_\_\_ (6) Other

Sex: \_\_\_\_\_ M \_\_\_\_\_ F

BEGINNING DATE OF PRACTICE IN WISCONSIN: \_\_\_\_\_ LOCATION: \_\_\_\_\_

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#### I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED)

By Written Exam: \_\_\_\_\_

By Endorsement/Reciprocity: \_\_\_\_\_

APPLICATION FEE: (Make check payable to Department of Regulation and Licensing and attach to application).

For Receipting Use Only

\$ 62.00	Initial Credential Fee
\$ 57.00	State Law Exam
<b>\$ 119.00</b>	<b>Total Fee Attached</b>

# State of Wisconsin Department of Regulation & Licensing

**APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:**

Fee attached to this application.

Notarized copies of an **original wall certificate and a current registration card** to practice physical therapy in another jurisdiction of the United States or Canada.

A letter from the employer requesting the applicants services.

A letter of recommendation from a physician or supervisor or present employer stating the applicant's professional capabilities.

Wisconsin Statutes and Rules Examination Booklet and answer sheet.

Addendum to Application Form (Form #2380).

**Application for licensure will be reviewed by members of the Physical Therapy Examining Council prior to issuance of a license.**

Documents received for this locum tenens license are not transferable to a permanent physical therapy license application file.
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## PROFESSIONAL EDUCATION:

School	Location	Degree	Date of Graduation mo/yr
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**PRACTICE:** Outline in chronological order all activities from the date of graduation from physical therapy school to the present time. Must include professional and non-professional activities. All time and dates must be accounted for.

NAME OF HOSPITAL OR CLINIC	LOCATION	DATES (from-to) mo/yr
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

# State of Wisconsin Department of Regulation & Licensing

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**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, NPTE examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and, if applicable, list name, address and phone number of your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
10. Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

# State of Wisconsin Department of Regulation & Licensing

For the purpose of these questions, the following phrases or words have the following meanings:

"Ability to practice physical therapy" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned physical therapy judgments and to learn and keep abreast of physical therapy developments; and
2. The ability to communicate those judgments and physical therapy information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform physical therapy tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrected lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 13. Do you have a medical condition which in any way impairs or limits your ability to practice physical therapy with reasonable skill and safety? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does your use of chemical substance(s) in any way impair or limit your ability to practice physical therapy with reasonable skill and safety? If yes, please explain.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

# State of Wisconsin Department of Regulation & Licensing

## AFFIDAVIT OF APPLICANT

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Physical Therapists Affiliated Credentialing Board or the Department of Regulation and Licensing will be cause for disciplinary action.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of  
\_\_\_\_\_, 20 \_\_\_\_\_

**S E A L**

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
State

My Commission Expires: \_\_\_\_\_

**NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.**

# Department of Regulation & Licensing

State of Wisconsin  
(608) 266-2112

TTY# (608) 267-2416, hearing or speech  
TRS# 1-800-947-3529, impaired only

P.O. Box 8935, Madison, WI 53708-8935

E-Mail: [dorl@drl.state.wi.us](mailto:dorl@drl.state.wi.us)

Website: <http://www.drl.state.wi.us/>

FAX #: (608) 267-1803

## ADDENDUM TO APPLICATION

Information requested is required for processing.

**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

\_\_\_\_\_  
First Name Middle Initial Last Name

			-			-				
--	--	--	---	--	--	---	--	--	--	--

Social Security Number or FEIN

\_\_\_\_\_  
Type of Credential

Date of Birth \_\_\_\_\_

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

## INFORMATION AVAILABLE TO THE PUBLIC - NONDISCLOSURE OF CERTAIN PERSONAL INFORMATION

☐ Your name, credential number, address, status and other credentialing information are available to the public. However, you may check this box to declare that your name and address not be disclosed on any list of ten or more individuals that the department furnishes to another person.<sup>5</sup>

## DELINQUENT STATE TAXES; DELINQUENT SUPPORT

All applications for professional credentials are checked to determine whether the applicant is liable for delinquent state taxes. Under state law, the department must deny your application if you are liable for delinquent Wisconsin taxes.<sup>6</sup> If you are liable for delinquent state taxes, pay the delinquent amount before the application process is completed. Retain proof that you have satisfied the tax delinquency. If you have any questions about payment of delinquent taxes, please contact your nearest Department of Revenue office or call (608) 261-6249. An application may be denied or a credential suspended if an applicant or credential holder is delinquent in paying support or fails to comply with a subpoena or warrant issued by the department of workforce development or a county child support agency related to support or paternity proceedings.<sup>2</sup>

#2380 (Rev. 10/00)

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996

<sup>5</sup> Section 440.14, Wis. Stats.

<sup>6</sup> Section 440.12, Wis. Stats.

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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## CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: \_\_\_\_\_

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) \_\_\_\_\_

Mail To Address (if different) \_\_\_\_\_

Date of Birth	Social Security Number
____ month ____ day ____ year	_____

Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: \_\_\_\_\_
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

<u>OFFENSE</u>	<u>DATE</u>	<u>CITY/STATE</u>
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Attach additional sheet(s) if necessary.



# Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED  
☐ ☐ \_\_\_\_\_  
Did you successfully complete the program? ☐ ☐ \_\_\_\_\_  
Please attach the certificate of completion/discharge summary.

- (Check all that apply)
4. Have you ever been sentenced to: YES NO MO/YR COMPLETED  
☐ Probation ☐ ☐ \_\_\_\_\_  
☐ Parole ☐ ☐ \_\_\_\_\_  
☐ Ordered to pay restitution ☐ ☐ \_\_\_\_\_  
Did you successfully complete one of the above as ordered by the court? ☐ ☐ \_\_\_\_\_

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
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Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.


## AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

Signature _____	Date _____
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Signed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Signature of Notary Public _____	Date _____
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My commission (is permanent) \_\_\_\_\_ expires \_\_\_\_\_.

**SEAL**

# Department of Regulation & Licensing

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Website: <http://www.drl.state.wi.us/>

FAX #: (608) 267-1803

## NOTICES

### **TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS**

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.<sup>a</sup> An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

### **PROCEDURES ON APPLICATION DENIAL**

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

### **MAILING ADDRESS AND CHANGE OF ADDRESS**

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

### **PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY**

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

### **AMERICANS WITH DISABILITIES ACT**

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

**Communications and examinations:** Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

**Complaints:** Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 10/00) ss. 15.04 (1) (m), 19.35, Stats.

<sup>a</sup> Section RL 4.06 of the Wisconsin Administrative Code

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Website: <http://www.drl.state.wi.us>

## APPLICATION PACKET ADDENDUM (INTERNET)

### Physical Therapist Locum Tenens application packet

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

### PLEASE PRINT OR TYPE

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
PO Box

\_\_\_\_\_  
City, State, Zip

Thank you.

#2612 (4/03)